

**ALASKA U.F.C.W. HEALTH AND WELFARE AND PENSION TRUSTS**  
**ENROLLMENT/DECLINATION OF COVERAGE/BENEFICIARY/DEPENDENT COVERAGE**

**F45**

**AUTHORIZATION FORM**  
**ANSWER ALL QUESTIONS & RETURN IMMEDIATELY**

PURPOSE FOR COMPLETING FORM: <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Beneficiary Change	
<input type="checkbox"/> Addition of Dependents <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change _____	<input type="checkbox"/> Other _____ Previous Name

**PAYROLL DEDUCTION AUTHORIZATION:** I authorize a weekly payroll deduction by my employer for health coverage for myself and/or my eligible dependents. You must check one of the following boxes to confirm who you will cover (or decline coverage):  
 Employee Only;  Employee + Child(ren);  Employee + Spouse and/or Family;  
 I Decline Coverage Until Next Open Enrollment

**\*A SPOUSE WHO IS ELIGIBLE FOR COVERAGE THROUGH HIS OR HER OWN EMPLOYER IS DISQUALIFIED FROM COVERAGE UNDER THIS PLAN IF HE OR SHE HAS NOT ELECTED/ACCEPTED SUCH COVERAGE.**

**Important Note:** *If you do not enroll your eligible dependents for coverage at this time, you will not be able to do so until the next annual Open Enrollment. Failure to complete and return this form will cause loss of health plan eligibility.*

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX M/F	BIRTHDATE (Month/Day/Year)	RELATIONSHIP TO MEMBER
Member/Employee				Self
Mailing Address (Street, City, State, Zip Code)				
Phone Number			E-mail Address	
Spouse* You must check the box above for weekly payroll deduction				Date of Marriage:
Dependent Children* You must check the box above for weekly payroll deduction				

**OTHER INSURANCE INFORMATION – YOU MUST COMPLETE THIS SECTION**

1. Are you, your spouse, or other dependents covered by or eligible to enroll in any other group medical insurance plan including Medicare? YES  NO  *If "YES," please provide the information requested below. If "NO," please go to #3 below.*

Name of Subscriber with Other Coverage \_\_\_\_\_ Subscriber Social Security Number \_\_\_\_\_

Name and Address of Other Insurance Company \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy or ID Number: If Medicare, copy of Medicare ID must be on file with the Administration Office.

2. Other insurance covers: Employee  Spouse  Children  Date Coverage Began: \_\_\_\_\_
3. Is your spouse employed? YES  NO  If yes, list employer: \_\_\_\_\_
4. Does spouse's employer provide access to group health insurance? YES  NO
5. If yes, was that coverage declined? YES  NO  Or accepted? YES  NO

**HEALTH & WELFARE/PENSION BENEFICIARY DESIGNATION**

If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference (if any) outlined in the Pension Plan Document or Health and Welfare Plan Document.

Beneficiary Name \_\_\_\_\_  
Last First Social Security Number

Beneficiary Address \_\_\_\_\_

Unless otherwise noted, if two or more beneficiaries are named, proceeds shall be paid in equal shares to the above beneficiaries.

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below. I am an eligible participant as a member of the bargaining unit, retiree, or covered by special agreement. I hereby expressly acknowledge that false information given to an employee benefit plan is a crime and a violation of AS 21.36.360.

Date: \_\_\_\_\_ Participant Signature (must be signed by participating employee) \_\_\_\_\_

**RETURN WHITE COPY TO THE ADMINISTRATION OFFICE: P.O. BOX 34203 – SEATTLE, WA 98124-1203**